February 13, 2017

MEMORANDUM FOR Healthcare Coalition Partners

SUBJECT: Healthcare Coalition Response Leadership (HCRL) Course Report

1. Application phase.

a. Initial notification. In late November 2016, Colorado healthcare coalition leads received initial notification that the first scheduled HCRL course was scheduled for the period 30 Jan – 3 Feb 2017. Without delay, this coalition emailed the designated course POC, Dr. Richard Hunt in Anniston, who immediately responded with the requisite application form. Instructions specified the following: (1) three healthcare coalitions of nine multi-discipline members each would be selected; and (2) the application was due within one week.

b. Applicant team composition. This coalition quickly solicited two leaders, two EMS reps, two emergency manager reps (one of whom was from a hospital), two public health reps, and the specified medically licensed team member. Every effort was made to include representation from rural counties; but due to a conflicting training course, most rural reps were unavailable during the scheduled course timeframe. The coalition's application with some background info (enclosure 1) was submitted and acknowledged on the suspense date.

c. Coalition selection. Within 3 days of applying, this coalition was notified of its selection from among the twenty-seven applicants. As POC for this coalition's team, I immediately informed each team member and asked them to confirm the requisite timeframe commitment. I also informed the CDPHE healthcare coalition liaison and selected council officers. Upon inquiring of the Center for Domestic Preparedness (CDP) regional training coordinator, this coalition learned that the other two selected coalitions were from Illinois and South Carolina respectively.

d. Individual team member registration. Accompanying the coalition selection announcement were instructions for individual team member registration. This included obtaining and using a FEMA Student ID number and CDP student portal password. Once logged in, all needed registration info was available on the CDP portal. One of the registration requirements was an online concurrence from the registrant's immediate supervisor.

2. Preparation phase.

a. Course documents. Once registrations were completed and approval confirmed via email, course-related documents became available for review. These included the Student Handbook and HCRL course guide or syllabus. Roughly two to three weeks prior to the course, several documents are posted to the student portal which must be completed online or downloaded. These include medical forms and travel information.

b. Preparing the team. In leading up to the actual course, the selected coalition team met for lunch to get better acquainted and to review the overall plan for the week (see enclosure 2). This plan included the cellphone numbers for each participating team members. On this occasion, the team briefly discussed the weather, clothing, and travel plan among other matters. The team agreed to meet after each classroom day in order to conduct a review of the day's

highlights. Included in this lunch meeting were the CDPHE healthcare coalition liaison as well as an adjacent coalition coordinator who is planning to apply for this course at a later date.

c. Travel plan. The first and last days are travel days while the middle three days are in a classroom setting. The CDP Travel Office makes all airline and charter bus arrangements for those registered for CDP courses. Flights arrangements are made only thru Atlanta airport (and not Birmingham although closer to Anniston). A course check-in desk is set up near the specified baggage carousel, and bags may then be loaded onto the charter bus. Students are then free until the scheduled bus departure.

d. Inprocessing. Upon arrival at the training site, incoming students were efficiently in-processed by the Student Services Office and Travel Office representatives. Individual rooms with share bathrooms were assigned proximate to the cafeteria. Meals, lodging, and airline travel are included for all those attending CDP courses; travel days per diem for meals and airport parking are reimbursed.

3. Participation phase.

a. Daily schedule (see enclosure 3). All days during the week started relatively early. The shuttle bus that took us to the classroom facility (about two miles away) departed from the lodging/main cafeteria area. A class photo was taken shortly after exiting the bus on the first day of class. That photo was later available on the student portal. Lunch meals were served in an alternate cafeteria adjacent to the classroom.

b. Course iPads. All instruction took place in a single classroom with nearby breakout rooms used daily. The course syllabus, slides, and glossary were pre-loaded onto a course iPad which was issued to each student at the beginning of class on the first day and then collected upon conclusion of the course. No course exam was used. Although course feedback used paper for this iteration, it appeared that the iPad would have one pre-loaded for future courses.

c. ASPR perspective. Since ASPR rep Melissa Harvey was present for this course, she addressed this class on the second day regarding the new emphasis on funding healthcare coalitions in order to improve overall healthcare preparedness. Melissa also indicated that the new Funding Opportunity Announcement (FOA) would shortly be released and published on the grants.gov website under PHEP/HPP. HPP grant funding is best justified by coalition success stories. She added that the congressionally-approved grant funds to awardees (typically state public health departments) would be deposited on July 1st. Contact stephen.tise@hhs.gov for inclusion on the ASPR e-mail list. Lastly, a good HHS contact is the (FEMA) regional field project officer.

d. Primary instructors. The three primary course instructors were Dr. Richard Hunt (course POC), Dr. John Hick (Medical Director for Emergency Preparedness at Hennepin County Medical Center in Minneapolis) , and Susan Snider (Executive Director for Northern Virginia Hospital Alliance). When we met in coalition groups, the primary instructors facilitated each breakout on a rotating basis. There was a contractor team shadowing them that was apparently being groomed to take over course instruction.

e. Course of instruction. Refer to syllabus which is posted on student portal. Key takeaways included the following: (1) under coalition governance, it's the function and not the form that matters for achieving the mission; (2) emergency management role becomes more apparent when the environment of care fails; (3) value of annual workplan and annual report; (4) how to ensure thorough ESF-8 communications regionally; (5) really knowing what coalition partners could contribute to incident response; (6) know what rules apply for EMS to transport to community health center like Peak Vista or to an ambulatory surgery center; (7) availability of 18-minute ICS 100 video at Memorial Hospital; (8) ESF-8 triggers are situationally dependent similar to what triggers EOC activation; (9) recommended ratio for casualty planning is 15% serious condition patients and 85% minor condition patients; (10) takeaway from Boston Marathon is importance of communication from incident to hospital regarding status of, and potential need for, decontamination; (11) N95 masks have a five-to-eight-year shelf life; (12)

potential use of cellular-on-wheels for augmented communications; (13) ad hoc mentality having fixed triggers for coalition engagement versus structured approach with softer triggers; (14) HPP grant-funded requirement for evacuation exercise; (15) ASPR website has training exercise tools.

f. Capstone exercise. This was accomplished separately by coalitions in breakout areas.

(1) Phase One covered a timeframe from start of the exercise until the first medical case was reported; it entailed discussion of an incident action plan (IAP) and need for consistent messaging; also addressed were the following: (a) resource assessment including PPE status; (b) protocols for prioritizing resource allocation; (c) disseminating info concerning first case confirmation;

(2) Phase Two covered period from initial case confirmation until full-on surge. Highlights included the following: (a) updating/refining the IAP; (b) prioritizing allocation of medical countermeasures; (c) strategies for addressing reduced staffing availability; (d) overnight capability of community health centers and ambulatory surgical centers; (e) consider homeless population.

(3) Phase Three covered period of full-on surge and entailed the following highlights: (a) updating/refining IAP; (b) establish pre-incident metrics for allotting constrained resources; (c) consider drive-thru clinics; (d) be mindful of fatality management aspects; (e) consider home health care population; and (f) one message although many voices.

(4) Phase Four – Recovery and Reconstitution. Highlights discussed included the following: (a) key role of behavioral health with all victims including responders; (b) engage nursing school students with provision for course credit; (c) reimbursement documentation for uninsured losses, unbillable items, and volunteer hours; (d) conducting hotwash (immediate AAR) by impacted facility; (e) conduct a medical debrief or coalition AAR; (f) plan for restoring broken relationships; (g) schedule community celebratory event(s) with certificates of appreciation; and (h) community events are recommended time for requesting contributions.

(5) Team feedback included the following: (a) think of alternate care facilities as a system and not as a location; (b) relook coalition strategy in view of HCRL course; (c) impart a response vision to coalition members by having a box of relevant questions at each meeting; (d) our sincere commendation to the staff who prepared the syllabus, presented the instruction, and facilitated the breakout sessions. See enclosure 4 for detailed team member feedback.

4. HCRL follow-up phase. Upon return home, all team members were asked for their feedback notes for incorporation into this overall course after-action report. <u>We highly recommend this course for other healthcare coalitions motivated to improve their operationalizing capability</u>.

Additional opportunities for sharing course highlights were the following:

a. Compile an overall summary report from application to follow-up;

b. Provide an article for inclusion in CDPHE's next monthly EPRNews;

c. Summarize course highlights for healthcare coalition council presentation;

d. Invitation to compile a slide presentation with voiceover from Waldo Canyon Fire experience for sharing with upcoming HCRL courses.

5. Point of contact for this report is the undersigned.

//ORIGINAL SIGNED//
Russ Roux
Colorado South Central Healthcare Coalition

Enclosure 1 – Coalition Overview

1. **Background**. This coalition was initially established as a metro medical response system (MMRS) when federal funds for that purpose were first allocated about 2001. The MMRS embraced a seven-county coalition which has remained intact even though today Pueblo and Fremont counties are integral to an adjacent regional healthcare coalition. In fall 2014 the network officially transitioned into a regional healthcare coalition. One year later the coalition was adopted under the umbrella of the El Paso County Medical Society Foundation and now welcomes its unique 501c(3) status among Colorado healthcare coalitions. At this time no Colorado healthcare coalitions receive any federal grant funds although some member organizations do.

2. **Governance**. This coalition is comprised of a leadership team (with elected chairperson and secretary-treasurer), a steering committee which acts like an advisory board, and numerous associate members. Coalition meetings are held quarterly and rotated among five counties with teleconference participation available for all meetings. Voting members must participate in at least three of the four quarterly meetings, either in person or by phone. Steering committee members agree to participate in work groups or coalition sub-committees as needed.

3. **Significant Activities**. Some of the major incidents in which this coalition had a stake include the following:

a. Waldo Canyon Fire (June 2012) – Thousands were evacuated including at least one large nursing home. In its aftermath, environmental health and behavioral health were heavily engaged. Based on feedback during the health & medical debrief, the coalition drafted an evacuation assistance plan. Closing the main highway from Colo Spgs going west resulted in lack of readily available medical resupply (oxygen, pharmaceuticals) to rural areas within the coalition's region. The US highway closure also resulted in a potential staffing shortfall for health & medical facilities as the only alternate route to travel between home and work was three hours around the mountain.

b. Black Forest Fire (June 2013) – Just one year later this community endured a similar experience with thousands evacuated and hundreds of homes destroyed. The coalition dedicated significant effort to contacting healthcare facilities, and especially focusing on home health agencies whose clients resided in the impacted area. Here again, environmental and behavioral health partners were heavily engaged. The coalition refined its regional evacuation assistance plan and improved its information sharing using a medical situation report.

c. Major Flooding (July 2015) – Due in part to unusually heavy rainfall coupled with deforestation from the 2012 fire, this major disaster was accompanied with landslides and mudslides. Evacuations were ordered and some low-lying buildings were inundated with mud. Thankfully, there were very few casualties in both fires and the flooding. In this instance, the city and county offices of emergency management began recognizing the coalition as a conduit to information sharing amongst medical partners.

d. Active Shooter (November 2015) – On Thanksgiving weekend, over the span of 5 hours, a lone gunman began shooting at the local Planned Parenthood. In this incident, three people on scene were tragically killed, including one law enforcement officer. Twelve people sustained injuries and were transported to local hospitals. Twenty-four others were evacuated unharmed from the Planned Parenthood building, and approximately 300 people sheltered in place in the surrounding businesses as the incident took place. As a result of this act of violence, hundreds of law enforcement personnel, their families and numerous members of the community were impacted by this incident. Coordination was imperative between the various hospitals, and also with new coalition partners - victim advocates - and the veteran's clinic that agreed to serve as victim staging area during evacuations. Our coalition members were involved in the immediate response and the aftermath of this event. Behavioral Health organizations continue to be a partnership this coalition highly values.

e. Other incidents included landslides and a train derailment with non-toxic chemicals in which a local hospital took all precautionary decon actions.

4. **Road Ahead**. With the implementation of CMS rule for emergency preparedness, this coalition is coming alongside new health and medical partners to assist them with implementing the new requirements. Work group meetings with long-term care facility representatives were held to provide them with an easy-to-use risk analysis tool. A current initiative is underway to host a tabletop exercise for all area ambulatory surgical centers.

5. **State-Level Forum**. In early 2014 Colorado established its healthcare coalition council which is comprised of healthcare coalition leaders from across the state. They meet semi-annually in person (March & September) and semiannually via telecon (June & December). Advisory members from the state health department and state hospital association actively participate with the council. This coalition has hosted two of the in-person meetings.

6. **Healthcare Coalition Response Leadership course**. When ASPR first announced this course over one year ago, this coalition contacted the CDP regional training coordinator to inquire about course availability. The coalition chairperson challenged the membership to undertake steps to "operationalize" the coalition. Such steps include the following: provide preparedness training, situational awareness for its partners in an emergency, and coordinate mutual support. Coalitions can also be leveraged to mitigate everyday healthcare challenges such as critical shortages of medical supplies and equipment to include ventilators, PPE, and resuscitation fluids; they can also promote crisis standards of care across the community. Seeking to participate in the HCRL course is another step in the direction of operationalizing.

Enclosure 2 – Plan for HCRL Week

Pre-Course Lunch Agenda

Introductions

Documents furnished to date – student manuals and HCRL course student guide.

Anniston long-range weather forecast:

	Mon, 1/30	Tue, 1/31	Wed, 2/1	Thu, 2/2	Fri, 2/3
Hi temp	49	50	65	51	53
Lo temp	23	26	35	32	
Daytime Condition	Cloudy	Sunny	Mostly sunny	Colder and rain	Cloudy

Sunrise at 6:40 AM Sunset at 5:15 PM

Travel plan & reimbursement – travel (from home) to, and parking at, COS airport is reimbursable.

Can download boarding passes anytime on Sunday (1/29)

Arrive COS airport by 5:15 AM Monday; departure gate is one closest to TSA area

Aircraft boarding begins about 5:30 and departure set for 6 AM (MST)

3-hr flight gets us to ATL about 11 AM (EST); with luggage we meet in South Terminal baggage claim area on the window side of Carousel 5 where CDP rep greets and checks us in; there we should be able to place luggage into charter bus and move about the airport until the time of bus departure.

Will need DL to board charter coach for two-hour bus ride to Anniston (along with those coming for several other courses)

Upon arrival at CDP have DL handy and be prepared for initial in-brief, to receive welcoming packet with forms for reimbursement claim, and room assignment with key.

We will likely be billeted in one of three dorms proximate to the cafeteria (bldg 17); cafeteria meal times are as follows:

- Breakfast 5:30 a.m.–7:30 a.m.
- Lunch at the training site
- Dinner 5:30 p.m.–7:30 p.m.

Shortly after breakfast, anticipate boarding a shuttle bus for the two-mile ride to Noble Trng Facility in the former army hospital. Lunch is served in the training facility, and snacks/beverages are available during training sessions.

Once training classes conclude for the day, students are free for the evening and may take advantage of shuttle bus service to downtown Anniston.

Team Feedback. I would like to propose that we huddle for about 30 min on Tue thru Thu at about 5:30 in the cafeteria for purpose of daily hotwash. Upon return to Colo, I would like to have your written or typed course highlights in order to compile a trip after-action report. Receiving your input by Friday 10 Feb while ideas are still fresh would be much appreciated.

My intent is to disseminate the overall summary to each of you and share that summary with the state-level healthcare coalition council at their in-person March meeting here in Colo Spgs.

Once the course is completed, students outprocess, board the charter bus to ATL airport, and return home. Our return flight is scheduled to depart ATL 12:15 PM Friday, arrive in Salt Lake City about 2:30 with 75-min layover, and arrive in COS about 5:30 PM.

When you have all receipts to include that for airport parking, follow the instructions for getting them and any other required documentation to CDP. Reimbursement for travel expenses is handled very expeditiously.

Questions

SCHC overview and initiative to establish contact with other two coalitions participating in this first course.

Cellphone numbers for each team member: (removed)
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Center for Domestic Preparedness (17R-0319 HCRL)
01/30/2017 to 02/03/2017

Arrival Day Monday, January 30. 2017

Start Time	End Time	Lesson	Location
4:30 PM	5:30 PM	No-host social	Bldg 251
5:30 PM	7:30 PM	Evening meal	Bldg 17
Day 1 Training			
5:30 AM	7:30 AM	Breakfast meal	Bldg 17
7:40 AM	7:45 AM	Photo ID check / shuttle bus depart	Bldg 251
7:55 AM	8:05 AM	Class photo	Bus disembark
8:05 AM	8:20 AM	iPad issue	Noble ClassRoom C
8:20 AM	9:20 AM	Intro to HCRL course	Noble CR C
9:20 AM	11:20 AM	Healthcare Coalition Framework	Noble CR C
11:20 AM	12:05 PM	Lunch	Noble Cafeteria
12:05 PM	2:35 PM	Healthcare Coalition Preparedness	Noble CR C
2:35 PM	4:50 PM	Healthcare Coalition Response Practical Application	Noble CR C and 1201 thru 1204
5:30 PM	7:30 PM	Evening meal	Bldg 17
7:00 PM	8:00 PM	Evening Lecture (optional)	Bldg 320
Day 2 Training			
Start Time	End Time	Lesson	Location
5:30 AM	7:00 AM	Breakfast meal	Bldg 17
7:10 AM	7:15 AM	Photo ID check / shuttle bus depart	Bldg 251
7:25 AM	9:25 AM	Healthcare Coalition Response & Recovery	Noble CR C
9:25 AM	11:25 AM	Indicators, Triggers, and Tactics for Healthcare Coalition Action	Noble CR C
11:25 AM	12:10 PM	Lunch	Noble Cafeteria
12:10 PM	12:25 PM	Travel Reimbursement Briefing	Noble CR C
12:25 PM	3:25 PM	Healthcare Coalition Response and Recovery Exercises	Noble CR C and 1201 thru 1204
3:25 PM	4:25 PM	Healthcare Coalition Response and Recovery Exercise After Action Review	Noble CR C
5:00 PM	6:00 PM	Meet and Greet (Optional)	Bldg 251
5:30 PM	7:30 PM	Evening meal	Bldg 17
Day 3 Training			
Start Time	End Time	Lesson	Location
5:30 AM	6:05 AM	Breakfast meal	Bldg 17
6:15 AM	6:20 AM	Photo ID check / shuttle bus depart	Bldg 251
6:30 AM	7:00 AM	Continuity of Operations for Healthcare Coalition Action	Noble CR C and 1201 thru 1204
7:00 AM	12:00 PM	Healthcare Coalition Response & Recovery Capstone Exercise	Noble CR C and 1201 thru 1204
12:00 PM	12:45 PM	Lunch	Noble Cafeteria
12:45 PM	1:45 PM	Healthcare Coalition Response & Recovery Capstone Exercise AAR	Noble CR C
1:45 PM	3:00 PM	Course Review and Open Forum	Noble CR C
3:00 PM	3:25 PM	End of course Evaluation & iPad Recovery	Noble CR C
3:25 PM	3:40 PM	Course Certificate Presentations	Noble CR C
5:30 PM	7:30 PM	Evening meal	Bldg 17

Enclosure 3 – Sample Daily Schedule

Departure Day – Friday February 3, 2017			
Start Time	End Time	Lesson	Location
5:30 AM	6:15 AM	Breakfast meal	Bldg 17
5:30 AM	6:15 AM	Bus available for loading / turn-in room key	Bldg 21
6:15 AM	6:30 AM	Busses depart for Atlanta Airport	Bldg 21

Enclosure 4 – Team Member Feedback

A. HCRL Course Hi-lights/Takeaways

1. The breakout exercise scenarios were very informative. More so with our coalition rather than with a group of the same discipline. I learned some things about each of our representative's capabilities that I didn't know.
2. Doing those type of short facilitated discussions may be something that we want to try in our meetings to get our members to start thinking of what they can do to benefit the entire coalition and not just their individual agencies.
3. Hearing from the other two coalitions helped me understand more of what obstacles they have gone through. Obviously, they receive some type of funding and we haven't; but I still believe that we are headed in the right direction. A more formal written process for our members will help with any confusion on roles and responsibilities.
4. I did not gain much benefit from the power point presentations. They were hard to follow. I realize that the instructors needed to show them, but I gained more from reading the information myself and listening to the larger group's discussion.
5. I would like to see all of our members be trained in EOC Operations. There may be a time where they would be able to assist the ESF-8 desk. Either EOC Generalist or Specialist training depending on the level that they want trained to. I do the training for our county volunteers.
6. Receiving funding and disbursing it in a fair and equitable manner is going to be a challenge. No matter how we decide as a group, there will be some agencies that will not think that it was fair because everyone always wants more. Some thoughts on disbursement could be that the agencies have to have a set projects showing a benefit to the coalition, be a member in good standing (longer than just short term and attend meetings), and possibly serve on a working group.
7. Overall, it was a good training and we learned that we are actually ahead in some areas.

B. Course Notes with Highlights

1. Operational coalition does not necessarily mean having "stuff" to use; it can be more about coordination of efforts during an incident.
    a. Situation reports
    b. Conference calls to share information (plans, who is doing what and when, etc.).
    c. Dr. Hunt – "Use the heck out of each other to achieve really cool things."
2. Finance Committee
    a. Consider options to diversify portfolio
        i. Member dues
        ii. Additional grants
        iii. Homeland Security
        iv. State grants
    b. Understand the rules/regulations for HPP funding
    c. Be familiar with additional rules, governance, etc. that can influence disbursement
    d. 501c – Different rules that can impact fund reception/disbursement. Fees to maintain
    e. How will CMS impact the process?

        i. HPP funds can be used for CMS participation
        ii. Touched on HHS Section 1135 Waivers
3. Networking prior to an incident vital for building relationships
    a. Mission = Vision = Goals/Objectives
    b. Establish common goals and common vision
4. Develop relationships with partners
    a. Understand each other's capabilities - "To know is to use it"
    b. What can partners actually bring to the table
    c. Resources, expectations, etc.
    d. Work with partners to engage critical infrastructure
        i. Supplies
        ii. Vendors (Medical durable like O2, etc.)
    e. Function more important than form; accomplishing mission not as important as *how* it gets done
5. Gap Analysis
    a. Identify areas in community/region that are lacking
    b. Can provide focus for HPP funding/projects
    c. Think outside the box to fill gaps (ex: GIS layers to locate special need/assistance populations in an area. Telemedicine in remote areas. Use EmPower!)
6. Triggers/Indicators
    a. Different agencies will have different indicators/triggers
    b. Indicator = Predictor
        i. Can be notifications/warnings
        ii. Situation dependent
    c. Trigger = Action
        i. Warnings may suffice for some.
        ii. Can result in crisis standards of care activating
        iii. Crisis, scripted, or non-scripted triggers
7. Consider special needs populations with plans
    a. Hospice
    b. Home Health
    c. Behavioral Health
8. Inventory Management
    a. Create caches
        i. Rotate the caches
        ii. Keep in mind expiration
        iii. Prevent exploitation of caches
        iv. Sustainment Vital!
        v. Who will maintain the cache (purchase powers)?
        vi. How will it be recycled?
        vii. Items used daily – consider member sustainment
        viii. Items used occasionally – consider HCC sustainment
    b. Don't rely on federal resources instead of caches

i. May not be available
ii. Takes time to request and deploy (i.e. SNS)
iii. Leverage member relationships for resources – fuel truck example
iv. Helpful role of MOUs

9. Plan development
    a. Utilize IAP structure as much as possible
        i. Include communications plan
            1) Radio communications
            2) Email, text, pager
            3) Updated contact lists for facilities & coalition members
    b. COOP
        i. Decision making
        ii. Data redundancy
        iii. Mission essential functions
        iv. Bug out kits
        v. Consider alternative methods (Google Docs, cloud drives)
    c. Integrate HCC IAP with other agencies as much as possible
        i. City & County OEM
        ii. ESF 8 Functions
        iii. Family reunification
    d. Remember the Planning P!
    e. Mobilization - Phased approach (expand to meet incident demands)
        i. Reactive to proactive strategies
    f. Surge Capacity
        i. CO-S-TR Model can help
        ii. Adjunct to HICS
        iii. Alternative methods to locate/move personnel and supplies
    g. Mental/Behavioral Health
        i. Leverage partners to provide response & recovery resources
        ii. Can utilize communication & coordination capabilities of the HCC
        iii. Consider creation of MIC for major incidents
        iv. CAPSTONE – Additional Resources may be able to provide emphasis/data backing
        v. Boston Marathon bombing AAR can apply to this
        vi. Planned Parenthood – EPC Public Health Music Festivals
    h. Responder Health & Safety
        i. Prophylactic care for responders and families
        ii. BH needs
        iii. Provide PPE
        iv. Help provide basic needs for responders
        v. Additional staffing
        vi. Food/water
        vii. Shelter
    i. Ethics Committee

i. Help establish/provide feedback for crisis standards of care
    1) Unintended consequences
    2) Contingency plans
ii. Can help with conflict resolution
    1) Establish guidelines/by-laws in advance to help with this
iii. Help with disbursement of supplies/materials
iv. Help with re-allocation of resources
v. Card set example: http://www.health.state.mn.us/oep/healthcare/crisis/standards.pdf)

10. Recovery
    a. Public/Private relationships vital
    b. Additional resources
    c. Subject Matter Experts
    d. Think collaboration and cooperation, not command

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